

LONDON BOROUGH OF HAVERING

Prevention of obesity needs assessment

2016

Executive Summary

Joint Strategic Needs
Assessment

*By London Borough of Havering
Public Health Service*

Executive Summary

Facts and figures

Definition of obesity

- Overweight and obesity is excessive fat accumulation that may impair health.
- Obesity is usually categorised in terms of Body Mass Index (BMI).
- BMI is calculated by dividing weight (in kilograms) by height (in metres) squared.
- People with a BMI of 30 or greater are obese; 25 – 29 are overweight.

Prevalence of obesity

- Levels of obesity in Havering are similar to the national average - more than a quarter of adults are obese and two-thirds are overweight or obese (110,000 residents).
- The prevalence of adult obesity in England has more than doubled in the past twenty-five years.
- Rates of morbid obesity have doubled in the last twenty years – to 2.7% of adults in 2014 (5,700 Havering residents).
- 1 in 10 Havering children (290) in Reception Year (age 4-5) are obese; almost a quarter of the children (680) are overweight or obese. Levels of obesity amongst Reception Year children resident in Havering are similar to those in London but significantly higher than England average.
- 1 in 5 Havering children (530) in year 6 (age 10 - 11) are obese; more than a third are overweight or obese. Levels of obesity in Havering for Year 6 children are similar to the London and England averages.
- Levels of obesity double from 1 in 10 to 1 in 5 during the primary school years.
- 70-80 children in each school year are likely to be severely obese – equivalent to an adult BMI of 35 or higher.
- About 1 in 5 women of child bearing age are obese.

Burden of disease and financial cost

- Obese adults are more likely to die prematurely (e.g. from cancer and circulatory diseases), develop limiting long term illness (e.g. diabetes and osteoarthritis) and experience mental illness (e.g. anxiety and depression).
- Maternal obesity is a risk in the short term to the health of both mother and baby but also increases the risk that the child and possibly their children may be obese.
- Obese and overweight adolescents have a third more sick days than peers with a healthy body weight as a result of the physical and mental health problems associated with childhood obesity.
- Obese children are between 2 and 10 times more likely to be obese in adulthood.
- Nearly 9% of the total UK burden of disease (measured in DALYS) is due to high BMI.
- The total cost of obesity to the UK economy is estimated at £27bn per year. Costs to the NHS alone are more than £6bn and projected to rise by a further £2bn if the prevalence of obesity continues to rise and more effective but expensive treatments are introduced.

What are the key inequalities?

- More men than women are overweight; more women than men are obese and morbidly obese.
- The prevalence of obesity varies between ethnic groups as does the risk of harm associated with a given BMI level. As a result, 'Black' and 'Asian' communities are at greater risk of obesity related harm.
- People with physical disabilities, long term health problems and learning disabilities are more likely to be obese.
- Adults, particularly women, living in disadvantaged communities are more likely to be obese than peers living in more advantaged communities.
- At both reception and Year 6, children in all but the 'White' and 'Chinese' ethnic groups have significantly higher prevalence of obesity than the average for 'all' children. The prevalence is particularly high amongst 'Black' children.
- Children with a limiting illness are more likely to be obese or overweight, particularly if they also have a learning disability – children with both conditions were almost twice more likely to be overweight or obese than children with neither.
- Obesity prevalence in children is strongly correlated with disadvantage. Prevalence in the most deprived decile is about twice that in the least deprived for both reception and Year 6 children.

Causes of obesity

Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the accumulation of excess body fat.

It is tempting to believe that obesity can be addressed by shifting decisions at the level of the individual. However, humans evolved in a world of relative food scarcity and hard physical work and now live in a world where energy-dense food is abundant and we have access to many labour-saving technologies. As a result, the majority of the population are now predisposed to gaining weight.

Therefore, action is needed to address the environmental and societal factors that contribute to 'passive' obesity to assist the individual – who may also benefit from support to initiate and maintain conscious behaviour change. To maximise the chances of success we must address all the factors driving the obesity epidemic. Taken together, their complementary and reinforcing action may achieve the significant shift in population obesity levels required.

Physical activity and healthy eating

Individuals and communities that eat well and are physically active are more likely to maintain a healthy body weight and will accrue many other benefits independent of the positive impact on obesity levels.

- Relatively modest levels of activity are recommended for adults – 150 minutes of moderate intensity physical activity per week.

- But only two-thirds of men and half of women in England get this amount; and levels of activity in Havering are lower still.
- Children and young people aged 5–18 year olds should get at least 60 minutes per day, which should be a mix of moderate intensity (e.g. walking to school) and vigorous intensity aerobic activity (e.g. playing football).
- Under–fives should be active for three hours, spread throughout the day
- But only 1 in 5 children aged 5 - 15 years and 1 in 10 children aged 2- 4 get the recommended level of activity.

In the United Kingdom, the Scientific Advisory Committee on Nutrition (SACN) publishes recommendations regarding the intake of energy, nutrients and some specific food groups. The potential benefit if everyone met these recommendations would be enormous e.g. more than 10% of deaths avoided and £6billion reduction in NHS expenditure.

- Average adult energy consumption is about 10% more than needed to achieve energy balance – equivalent to 4 chocolate digestives or a can of soft drink too much each day.
- Sugars (1/2) and fats (1/3) account for the majority of energy intake.
- SACN has recommended that free or added sugars should make up no more than 5% of energy intake – equivalent to 7 sugar cubes for adults per day; less for children.
- Only 4% of children and 13% of adults meet the SACN recommendation about free sugars and average consumption by young people is three times the recommended amount.
- Levels of 'healthy' and 'unhealthy' eating vary with age, gender, ethnicity and disadvantage. Very few people with a learning disability eat well.

Healthy nutrition in early life is of crucial importance

- Both maternal under- and over-nutrition around the time of conception and during pregnancy increases the risk of childhood obesity.
- Pregnant women are advised to consume only an additional 200 kcal/day in the last trimester – and definitely not to 'eat for two'.
- Babies that are breastfed are less likely to become obese. But a quarter of babies born in Havering are not breastfed at all, and 6 out of 10 are bottle fed by 6-8 weeks.
- Delaying weaning until babies are at least six months old reduces the likelihood of obesity.

What works?

To prevent people becoming obese, and increase levels of physical activity and healthy eating, local partnerships should: -

- reduce the environmental and societal factors that contribute to passive obesity and replace them with 'cues' or 'nudges' for healthier choices.
- work to make more people perceive obesity, healthy eating and physical activity to be issues that affect them personally; prompting them to take up the available opportunities to be more active and eat more healthily.
- focus on early years as weight is difficult to lose once gained and the attitudes and behaviours established in childhood serve to shape our lifestyle in later life.

- seek to remedy the inequalities regarding obesity, physical activity and diet that affect specific communities and population groups.

Current activities and future opportunities

Shaping the physical activity environment

Creating 'healthy streets'

For many people, walking, whether for pleasure or travel purposes, represents the most likely sustainable form of physical activity. Residents are more likely to walk when commonly used amenities are relatively close by and the street scene is 'inviting'.

The Council fosters ever healthier streets in a variety of ways e.g. through

- structural improvements to the street scene,
- high standards of street cleaning and maintenance,
- using spatial planning to ensure new housing is well served by public transport and has a range of high quality amenities in walking distance,
- encouraging new enterprises to locate to local centres etc.

Improving the public transport offer in the borough

A quarter of Londoners already get their recommended daily physical activity as part of a longer commute by public transport. But Havering has the lowest percentage of commuting by public transport of any London borough. Havering also has the 2nd lowest Public Transport Accessibility Levels (PTALS) of any borough in the capital. Improving access to public transport would boost levels of physical activity as well as contribute to a range of other priorities.

The Council and TfL have a number of priorities for public transport including:

- Romford Station – improvements with Crossrail
- New station at Beam Park to serve London Riverside area
- Rainham regeneration
- Improved north-south bus links and better links between hospitals

Maintaining and improving access to high quality green space

Parks and green spaces provide safe and attractive spaces in which to walk, cycle and play. Access to good quality green space is associated with a range of positive health outcomes including lower levels of overweight and obesity.

Havering as a whole has a large number of parks and open spaces, which make it one of the greenest boroughs in the capital. The borough contains a number of nature reserves, including an area of Special Scientific Interest. The majority of residents have good access to playgrounds and outdoor gym facilities.

Improving the 'cyclability' of Havering

Cycling improves cardiovascular health, is kind to joints and is associated with increased longevity. However, relatively few people in Havering cycle compared with other London boroughs. Since 2012, Havering has been a 'Biking Borough' and is actively addressing barriers to cycling.

[Considerable activity](#) is underway to increase rates, supported by £600K funding from TfL including the development of dedicated cycleways and 'greenways', regular bike security marking events, organises 'led' rides around the area, as well as a variety of riding and maintenance courses. The cycle to work scheme assists employees to buying a bike.

Road design

Actual and/or perceived safety influences decisions about whether individuals choose to walk or cycle or whether parents allow their children to do so. Good road design, including the use of 20mph limits in priority areas, reduces the likelihood of accidents and their severity should they occur.

Shaping the food environment to promote healthy eating

Central to tackling obesity and other diet-related poor health outcomes is creating an environment where it is normal, easy and enjoyable to eat healthily.

While reducing intake of saturated fat, sugar and salt and increasing intake of fruit, vegetables, dietary fibre and oily fish remain central to promoting a balanced diet, much of the current policy focus is targeted at reducing sugar intake.

Environmental variables that have an influence on eating patterns can be grouped into four overlapping areas:

- Community nutrition environment (type, location and accessibility of food outlets);
- Organisational nutrition environment (home, school, work and other settings);
- Consumer nutrition environment (availability, cost and promotion or placement of healthy options);
- Information environment (media and advertising).

Shaping the community environment (type, location and accessibility of food outlets)

Food businesses are an essential part of a vibrant, healthy and prosperous high street. However, a balance needs to be struck between commerce and health. Too many fast food outlets selling cheap, energy-dense, nutrient-poor foods, served in larger portion sizes, is detrimental to the health of local communities.

Analysis by PHE demonstrates that fast food outlets are concentrated in disadvantaged communities thereby contributing to local health inequalities. The same analysis demonstrates that Havering, although not particularly disadvantaged, has a relatively high concentration of fast food restaurants, in common with many other London boroughs.

The National Planning Policy Framework (NPPF) makes clear that local planning authorities (LPAs) have a responsibility to promote healthy communities. To this end, local plans should 'take account of and support local strategies to improve health, social and cultural wellbeing for all'.

Both NICE and PHE recommend that planning authorities restrict planning permission for takeaways and other food retail outlets in specific areas for example, within walking distance of schools. Given that Havering already has a relatively high number of fast food outlets, schools should also consider more direct action e.g. restricting pupils to school premises at lunchtime.

Organisational nutrition environment (home, school, work and other settings)

Large sections of the population rely on others to buy, prepare and serve food on their behalf for a significant number of their meals e.g. children and young people in pre-schools, schools and colleges, patients in health care settings and people in residential care. For some people, this may be all the food that they eat. These individuals rely on the providers of their food to plan menus in such a way that it is possible for them to meet dietary recommendations.

Using food and nutrient-based standards as a framework on which to base menus will help to ensure that people can achieve dietary recommendations. A much larger proportion of the population would benefit if the food in workplaces was also guided by these principles.

Consumer nutrition environment (availability, cost and promotion or placement of healthy options)

The previous government initiated the public health responsibility deal to encourage the food and drink industry to work with it to improve health as opposed to legislating to enforce change.

The responsibility deal included a calorie reduction pledge to provide a mechanism for the food and drink industry to make and record its contribution to reducing the population's energy intake and 43 manufacturers have done so.

PHE, in their analysis of how intake of sugar might best be reduced, advocates for many of the interventions voluntarily put in place via the responsibility deal (e.g. reformulation of products to reduce sugar content). However, PHE recommends that such approaches should be adopted industry wide thereby undermining the voluntary approach behind the public health responsibility. Moreover, PHE has also stated that financial measures e.g. a sugar tax would be effective.

Campaigners have sought to demonstrate to central Government that such measures would be publically acceptable e.g. by placing a self-imposed levy of 10p to the price of soft drinks with added sugar to heighten consumer awareness of hidden sugars.

Information environment (media and advertising)

The available research evidence shows that all forms of marketing consistently influence food preference, choice and purchasing in children and adults.

PHE recommends that Government should set a clear definition for high sugar foods and thereafter take action to significantly reduce opportunities to market and advertise high sugar food and drink products to children and adults across all media including digital platforms and through sponsorship.

PHE recommends that campaigns such as Change4life should be continued to raise awareness of concerns around sugar levels in the diet, encourage action to reduce intakes and provide practical steps to help people lower their own and their families' sugar intake.

Creating a healthy community

Leadership and 'walking the walk'

The Health and Wellbeing Board is ideally placed to provide strategic leadership; the adoption of a strategy to tackle obesity is an essential first step.

More importantly, public sector agencies must then demonstrate to their staff, clients, patients, Council Tax payers, etc. that they take health seriously. If not, they will undermine their own efforts to motivate individuals to change and adopt healthier lifestyles.

Key opportunities to 'walk the walk' include:

- putting in place a high quality healthy workplace offer.
- active participation in national health improvement campaigns.
- ensuring health professionals, the wider public sector workforce and the premises they work from actively promote healthy choices.
- ensuring all corporate decisions are assessed for health impacts.
- recognising and fostering the contribution of the community and voluntary sector.
- engaging the business community in health improvement.

Healthy working places

Every employer has a vested interest in ensuring the good health of its workforce so sickness absence is minimised and service delivery improved. Obese employees have more and longer sickness absences than workers of a healthy weight. Effective healthy workplace schemes in the statutory sector would benefit a significant minority of households in Havering given that a high proportion of Council and NHS employees are local residents.

The [London Healthy Workplace Charter](#) is a self-assessment framework that recognises employers for investing in workplace health. It provides a series of standards for workplaces to meet in order to guide them to creating a health-enhancing workplace. London Borough of Havering reached the 'Achievement' standard in 2014.

Ensuring public sector premises support healthy choices

Nudge theory suggests that the available options can be presented in such a way as to favour a desired outcome whilst preserving the individual's ability to choose. Nudges may vary from simple promotion of healthy options e.g. sign posting the stairs as opposed to the lift or putting fruit by the checkout as opposed to confectionary to more direct incentives (e.g. making healthy food options noticeably cheaper than less healthy ones). A periodic audit of the environment in which statutory sector services are provided to identify opportunities to nudge in favour of healthier options would add value and ensure that health improvement messages are not unintentionally undermined.

Enlisting the wider workforce to promote healthy choices

The Making Every Contact Count (MECC) concept draws on the established role of health professionals, particularly in primary care, who provide opportunistic brief advice to patients about lifestyle related issues. There is good evidence that such advice has a small but measurable impact on the behaviour of patients e.g. provision of brief advice about smoking by a doctor produces 1 additional quitter for somewhere between every 33 to 80 patients offered advice. The national aspiration is to extend this approach to all NHS staff, clinical and administrative; in primary care, community and acute hospitals settings.

The Council has developed a 'health champion' scheme called '[my health matters](#)' which fits with the MECC concept. Tapestry, a local VCS provider has been commissioned to recruit and thereafter manage a network of community health champions drawn from employees and residents.

Health impact assessment of corporate decisions

A complex array of factors has an impact on obesity levels. As a result, it may be difficult to identify which decisions, and by whom, will or won't impact on obesity levels, still less on health in the round. Health impact assessment (HIA) is a process whereby significant decisions by public sector agencies could be reviewed to identify potential health impacts so that potential benefits can be maximised and potential harms mitigated. A light touch HIA process, analogous to the existing Equality Impact Assessment process, would over time work to ensure that the collective decisions of the public bodies improve health.

The community and voluntary sector contribution

Community groups can drive health improvement in many ways. Most obviously in the context of obesity prevention, a huge range of sports and active leisure options are provided by third sector organisations. The Council and other public bodies should continue to support the community and voluntary sector to support residents to live more healthily.

Engaging the business sector

The local business sector has huge resources, energy and innovation. Yet this analysis has identified very little positive input to healthy living in the borough – beyond the obvious employment opportunities provided and income resulting which are crucial determinants of health.

More research may identify a greater contribution. Either way, more consideration should be given to how the private sector could be involved e.g. involvement in campaigns, healthy workplace schemes etc.

Supporting individuals to change

Health improvement campaigns

Effective campaigns have a role to play in changing attitudes with the ultimate aim of changing social norms such that the healthy choice becomes the usual choice for the majority. National bodies, primarily Public Health England have developed a number of increasingly sophisticated and successful campaigns such as Change4Life '10 Minute Shake Up' campaign with Disney; 'Couch to 5K' and 'sugar smart'.

Local agencies have neither the resources or expertise to develop similar campaigns but we can seek to amplify the message and use it to promote relevant local resources e.g. the Council's Sport Development Team badged programmes of activity for women and girls under the 'this girl can' banner to tie in the Sport England campaign. Campaigns should be coordinated across the partnership and linked to the 'MECC' activity of health care workers and health champions everywhere.

NHS Health checks

NHS health checks are one of the Council's mandated public health responsibilities. As part of a holistic assessment of cardiovascular risk, they are an opportunity to periodically advise ostensibly healthy adults aged 40 – 74 years about the benefits of maintaining a healthy bodyweight and signposting to sources of support and advice that might help them do so.

Weight management services and clinical interventions

Lifestyle weight management programmes and health care interventions form part of the overall care pathway for obese people.

- The Council is responsible for tiers 1 and 2, including population level interventions to encourage healthy eating and physical activity, as well as lifestyle related weight management services
- The Clinical Commissioning Group is responsible for tier 3, clinician-led specialist multidisciplinary teams
- NHS England is responsible for commissioning tier 4 services, including bariatric surgery

What is provided is a local decision, reflecting the local priorities and resource constraints. The bulk of this assessment has described activity that could broadly be categorised as tier 1.

Tier 2 lifestyle weight management programmes are multi-component programmes that aim to reduce a person's energy intake and help them to be more physically active by changing their behaviour.

NICE recommends that adults who are obese, that is with a BMI over 30 kg/m², or lower for those from black and minority ethnic groups or with other risk factors e.g. comorbidities such as type 2 diabetes may benefit.

The expected outcomes from an effective programme include completion by at least 60% of participants, resulting in an average weight loss of 3% or more, with at least 30% of participants losing 5% or more of their initial weight. Weight losses of between 5 and 10% in overweight and obese individuals with type 2 diabetes have been associated with significant improvements in CVD risk factors at 1 year; but those with larger weight losses benefit more. Services achieving modest weight loss are cost effective if that weight loss is maintained for life. There is a lack of evidence that this is the case – hence tier 2 services commissioned by the public sector are only probably effective / cost effective and unlikely to be harmful. The same can be said for a number of commercial weight management programmes.

A tier 3 obesity service is for obese individuals (usually with a body mass index of 35 and over with co-morbidities or 40 and over with or without co-morbidities) who have not responded to previous tier interventions; comprising a multi-disciplinary team of specialists, typically including: a physician specialist nurse; specialist dietician; psychologist or psychiatrist; and physiotherapist/physical activity specialist. Patients may respond well to intense support from tier 3 services and lose significant weight; they are also essential in preparing patients for bariatric surgery.

Tier 4 services provide bariatric surgery – a highly specialised intervention, offered to carefully selected patients with severe and complex obesity that have not responded to all other non-invasive therapies. In such patients, it is effective and cost effective, i.e. significant weight loss results; health outcomes improve and hence the overall cost of care is reduced such that within 2 – 3 years the initial cost of surgery is offset. Very small numbers of patients undergo bariatric surgery – as is the case nationally.

The obesity pathway in Havering needs to be clarified. Tier 2 services are currently not commissioned and information about reliable self-help aids and effective commercial providers have not been collated. Tier 3 services have not been commissioned. The tier 4 provider is supporting prospective bariatric surgery candidates but a local service would be more convenient. Likewise, the support available to children and young people with weight problems and their families also needs clarification and agreement.

Giving children and young people the best start

There are numerous reasons why children and young people should be our priority over and above the obvious moral obligation to protect the vulnerable; not least because losing weight in later life is difficult; and experiences in early life, indeed before birth, predispose individuals to obesity in adulthood.

As with obesity in general, there is no single silver bullet to the problem of childhood obesity. There are numerous opportunities to intervene, many of which would benefit parents and the wider community.

- Support to obese women pre-conception and during pregnancy would reduce foetal programming – which predisposes their offspring to obesity in later life.
- The promotion of breast feeding and healthy weaning is crucially important in reducing the likelihood of excessive weight gain during the early years and establishing preferences for healthier foods.
- Midwives, health visitors and children's centre staff have a potentially crucial role if adequately resourced and trained to identify at risk women / infants; and offer effective support to change unhealthy behaviours.
- Action to assisting parents with the knowledge and skills necessary to cook healthily may help. As would support and guidance to nurseries and childminders who assume direct control of the child's diet and activity for significant periods.
- Schools have enormous potential; providing children with a healthy environment and assisting them to make healthier choices. The curriculum offers opportunities for children to learn practical cooking skills; be active for significant periods and develop the knowledge and attitudes that underpin healthy living in adulthood. Extensive assets, developed over a long period, relevant to sport and PE are evident in the borough; the same can't be said with regard to diet and cooking skills.
- The healthy schools award programme has been well received and has motivated a large number of schools to systematically review their contribution to the health of their pupils and how it can be improved; action regarding healthy eating and physical activity is a particular focus.
- School meals are of a consistently high standard; further work is needed to encourage still greater uptake and assist children to make healthy choices from the available menu.
- School transport plans can increase levels of physical activity – for children and parents – and reduce congestion around schools.
- The National Child Measurement Programme, carried out in schools, is an opportunity to raise awareness and prompt action by parents.
- The views of peers can be particularly important to children and young people and we should consider how we involve young people in improving their own health. Youth health champions are one possibility.

Tackling inequalities in obesity

There are very significant inequalities in the prevalence of obesity between communities and population groups. Focusing on the early years is crucial to narrowing inequalities in obesity. As stated by Marmot, "*Giving every child the best start in life is crucial to reducing health inequalities across the life course. (We need) to increase the proportion of overall expenditure allocated to early years, and it should be focused proportionately across the social gradient to ensure effective support to parents, starting in pregnancy and continuing through the transition of the child into primary school.*"

Health visitors, working with early years staff, are uniquely placed to support with the transition to parenthood; breastfeeding and healthy weaning which are crucial to the prevention of childhood obesity during the early years. Strengthening Havering's under resourced health visiting team should be a priority.

Residents with a learning disability appear particularly vulnerable to obesity, poor diet and sedentary lifestyles. Further work with professionals, carers and people with learning disability is needed to identify opportunities for improvement.

What should we be doing next?

This needs assessment has been undertaken to inform development of an obesity prevention strategy requested by the Havering Health and Wellbeing Board. Therefore, a strategy and action plan, and systems to effectively coordinate and report on progress are essential first steps.

The content must be decided on by the Health and Wellbeing Board, having considered the evidence presented here, but also the wider priorities of the Board and its constituent bodies, and the resources available to support delivery, both financial and human. This assessment suggests 3 broad streams of work:

- Shaping the environment to promote healthy eating and physical activity
- Supporting a culture that sees physical activity and healthy eating as the norm
- Prompting individuals to change, primarily through self-help.

A focus on children and young people – particularly the early years is essential, both to reduce levels of obesity amongst children – but also tackle the significant inequalities associated with social disadvantage.

Key opportunities to tackle obesity are within the gift of central Government rather than local partners e.g. regulation of the food industry. Local partners should take any opportunities that arise to encourage central Government to take effective action.